

S. No. 2
M-9-4-41
Rev. 5-17-39
X29484

37088

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED DEC 5 1942 128

Registration District No. 312

Primary Registration District No. 2000

Registrar's No. 794

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 775 E. PACIFIC. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 684R years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene

(c) City or town Springfield
(If outside city or town limits, write "RURAL")

(d) Street No. 975 E. Pacific
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country. 0

3. (a) PRINT FULL NAME ALLIE M. GOODSON

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 5
year 1942 hour Approx 2 minute A. M.

21. I hereby certify that I attended the deceased from Nov 2
1942 to _____ 1942

that I last saw her alive on Nov 2 1942
and that death occurred on the date and hour stated above.

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife Wm. A. GOODSON

6. (c) Age of husband or wife if alive Dec years

7. Birth date of deceased NOV. 23 1873
(Month) (Day) (Year)

Immediate cause of death Coronary Artery thrombosis 2055 hr

Due to Coronary Sclerosis

Due to Chrt Hypertensive Cardiovascular renal disease

Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years 68 Months 11 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace SPRINGFIELD MO. 0
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business IN HOME

MOTHER FATHER { 12. Name MACK SOUTHERN

13. Birthplace Unknown TENN 1
(City, town, or county) (State or foreign country)

14. Maiden name CORNELIA HAMBLEN

15. Birthplace Unknown UNKNOWN 9
(City, town, or county) (State or foreign country)

Major findings: Of operations 12/10

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Charles Goodson

(b) Address Springfield, Mo

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Nov 8-1942
(Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn (Am) W. Klingner & Co.

18. (a) Signature of funeral director [Signature]

(b) Address Springfield, Mo

19. (a) 11-7-42 (Date received local registrar)

(b) A. W. Handy (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Arthur D. ... (M. D. or other) MD

Address Springfield Mo Date signed 11-7-42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

39
6
2

784 (Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Ray A. [Signature]*
Licensed Embalmer No. *1763*
P. O. Address *[Signature]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.